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AUTHOR McLaughlin, Judith
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ABSTRACT

Rural America is undergoing rapid and confusing change which impacts on the role of rural health educators and practitioners. Although rural life has been romanticized, rural areas have emergencies and accidents remote from professional assistance, occupational diseases, high infant and maternal mortality rates, and the same high incidence of hypertension, cardiovascular diseases, and strokes as urban dwellers. Like other rural dwellers, rural health educators must be generalists--capable in many content areas, proficient in grant writing and evaluation, able to cut red tape, willing to travel anywhere to do health promotion, and able to teach children, the elderly, and teenagers all in the same day. Unfortunately, specialization and credentialing requirements have impaired the ability of rural health care systems to find appropriately trained individuals. Fortunately, there has been a tremendous emergence of comprehensive self-care programs for rural areas. For persons who want to work in rural areas, or for those preparing health educators for employment in rural communities, the following are among the 11 suggestions provided: understand that principals of community organization and involvement are among the most important; combat professional isolation by developing strong linkages with whatever health care providers and facilities there are; try not to reinvent the wheel; be patient; and be adaptable. (BRR)

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Rural Health Care Delivery:

Hard Times, Hard Changes

by

Judith McLaughlin, Ph.D.
University of Georgia
Dept. of Health Education
Athens, Georgia 30602

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These are not the best of times nor the worst of times for Rural America, but they are rapidly changing, confusing and contradictory. At this time, the fate of many major Federal programs is in doubt; however, potential solutions to these problems can be extracted from the enormous amount of experience that we have collected in providing health care in a variety of rural settings.

My presentation today will concern the role of health and other professions today in rural areas. I am going to discuss some of the changes with regard to rural life in general, than talk about some of the issues that shape the practice for those of us who have an interest in rural health, and finish up with some ideas for practice that I have gleaned from my own experience and from talking with other rural health educators and practitioners.

Rural life is definitely undergoing a resurgence. Our society is becoming more decentralized, large urban centers are losing population, and many people are choosing to live in rural areas. Yet until recently, rural areas have been places where people came from, places that were left behind in the quest for education, better jobs, or the excitement of the city.

More than 1/3 of Americans live in non-metropolitan areas. The distinctive characteristics of a rural area are its low population density, its distance from urban resources, and the small sizes of the involved communities. There is a traditional association between rurality and agriculture, though actually this is a misnomer. In truth rural America is characterized by a diversity of occupations. Farmers might remain the most tightly organized and politically powerful of rural groups, but they aren't the majority of rural dwellers any longer.

Rural dwellers have a different approach to the solution of problems, and in any health education program their attitudes and beliefs must be taken

into account. Rosenblatt and Moscovice have noted that rural dwellers are inherently more conservative, unbending, and independent, and that role constraints are more rigid and community interactions are more intense and important.(1) On the other hand, rural people are beginning to recognize the value of their way of life, and are less apt to apologize for their background. In a recent article in the National Geographic about the Chatooga River Country of north Georgia, author Lon Belt writes that the people are trying to hang on to the remnants of their culture amid the change that threatens them. He says "they aren't the easiest people in the world to know. They're hard as nails and gentle, complicated and simple, religious and irreverent - straight faced, Bible reading people, fearsome in anger and exceedingly slow to forgive. Yet they're the friendliest, most hospitable people you could ever hope to meet - folks who will do anything for you except to give up their pride."(2)

One of the substantive issues regarding rural health care is that many people have romanticized rural areas and rural life; they think of a rural environment as decorated by tree and glade, graced with a cool breeze and delicate flowers, with a healthy, tanned farmer tending his contented cows. Unfortunately rural areas are characterized by grisly farm machinery accidents, occupational diseases such as brucellosis and histoplasmosis, mental illness, high infant and maternal mortality rates, and the same high incidence of hypertension, cardiovascular diseases and stroke that urban dwellers have.

Another issue is that rural communities are particularly susceptible to the effects of emergencies and accidents. Some rural professions carry with them a much higher incidence of accidental injury. These include logging, farming and fruit picking. Injuries account for a significant proportion of all rural health care problems. The scattered nature of rural settlements can transform a routine accident into a potential tragedy. The injured person may not be

discovered in time, and help is often remote because of the distances involved. As Waller points out, for most types of injury resulting in death, those injured in rural areas more frequently die in the first hour. This increased death rate is due not to the increased severity of injury in rural areas necessarily, but because of the generally delayed response to it.(3) In the development of a rural health care system, the emergency service component should receive top priority. Personnel, transportation, communication dispatches, the role of the hospital, and training of volunteers are extremely important. One problem has been that despite the initial federal investment into EMS, there was little consideration for the replacement of aging equipment or the operational costs of the system. The future viability of the system is dependent on the ability of local areas to continue to manage and improve what they have already started - certainly no easy task. Of vital importance in rural areas too are the establishment of first aid and CPR courses for rural people; this is certainly not a new idea. Knowledgeable care during the sometimes lengthy wait for emergency are may make a life or death difference.

It has been historically proven that in the rural environment, enterprises of all kinds are built on generalists. Because of the small, remote populations, teacher, mechanics, and healthy professionals all must be able to operate effectively in broad areas. Smaller health care systems cannot depend on specialists, and this pertains to nurses, administrators, technicians, dietitians, physicians, and others. As Rosenblatt and Moscovice note, rural professionals must be comfortable with uncertainty, challenged by diversity, and flexible in their skills, in their working hours, and in their interpersonal style.(1) Nurses in rural hospitals are called on to accept responsibility for obstetrics, newborn care, and intensive care, occasionally all at the same time. Administrators must be able to deal with personnel, create budgets from almost nothing,

purchase supplies such a kitchen items and laundry supplies for the hospital, and manage mayors and county commissioners. Health educators must be proficient in a number of content areas, be proficient in grant writing and evaluation, be able to cut through a mass of bureaucratic red tape, willing to travel to remote areas to take advantage of community meetings to give health promotion, and sometime teach children, the elderly, and teenagers all in the same day. In many cases, narrow educational experiences might not be adequate preparation for such an assignment. Competent, confident generalists are necessary for rural areas.

A paradox is that specialization and credentialing have impaired the ability of rural health care systems to find appropriately trained individuals. In nursing, for example, some academic leaders of the profession would like to require all registered nurses to complete a four year baccalaureate degree program in order to be eligible to work as nurses. This has a number of advantages, but it could also increase the length and expense of training, concentrate power in the hands of a small number of educational institutions, and probably restrict the number of people obtaining nursing degrees. In rural areas the supply of nurses would be smaller, the costs of hiring them would increase, and they might not find working in rural areas so attractive.

Credentialing is parallel. As individual groups increase the length of their curricula and see themselves with specialized skills and standards, quality of care might increase somewhat, but so also would the cost. Small hospitals can't afford to hire many specialists. Generalists are needed to maintain the resilience and stability needed in rural areas.

To the extent possible, functions should be integrated. Most rural communities cannot generate enough demand to support multiple health care systems, and duplication of services should be avoided. Consolidation also reduces the

amount of time and money that must go into administrative overhead. Single purpose programs compete for the same limited number of clients, as well as compete for professionals who would work in rural areas.

Many rural areas display an apparent paranoia about working in cooperation with other communities. Part of this fear is justifiable, part is illogical. Rural communties need to work together in building sensible regional networks, rather than dissipate their energies competing fruitlessly with each other.

A huge problem for rural areas are the wide, sudden swings in public policy and direction. Rural health concerns are often pushed back and forth by sudden shifts in the philosophy and program structure of the newest administration. Those health educators who deliver health services waste a lot of energy reacting defensively to the latest threat, and there have been many of these lately. We need clear objectives to guide us.

If local communities want to have the kind of health services that fit their needs, they must be intimately involved in shaping the system. Health fairs, fund-raising drives, open houses, newspaper stories, and elections for members of various health related community boards build a strong base for support. If people play a part in their system, they are more likely to trust it and to use it. Also rural health care systems depend on volunteers for such things as emergency health services. Other health programs can also be handled by volunteers - home visiting programs, working in hospital and nursing home auxiliaries, and participation in health planning bodies all strengthen the local health system at the same time they increase local involvement. The effect is that it increases community ownership.

Fortunately, there has been a tremendous emergence of comprehensive self-care programs for rural areas. The focus is self-diagnosis and self-management.

Consumers in rural areas need education more than ever to assume responsibility for themselves, since health care providers are in such short supply in many areas. Outcomes of these programs include better decisions by individuals regarding their own health, and greater self-reliance and effectiveness in dealing with health problems in the home setting. John Naisbitt, in his book Megatrends describes ten trends that will shape our future. He notes that trends start from the bottom and go up, fads start at the top and go down. An important trend is the fading of what he terms "institutional care" and the resurgence of "self-care."(4) I believe this portends well for rural areas.

There have been many public and private attempts to improve rural primary care, but there are many gaps. The social programs of the 1970s have for the most part helped rural communities obtain health services, but many of their efforts have been fragmented, poorly coordinated, or poorly managed. We are losing many of these programs now, and the involvement of the local community is more important than ever. Increased coordination is needed particularly since federal support for rural health is waning.

One promising development are the development of rural HMOs. Twenty percent of all funds set aside under the federal HMO Act of 1973 were for rural operations. There have been major obstacles, such as the inadequate supply of physicians and a sparse population, but there are examples of successful rural HMOs such as the Greater Marshfield Community Health Plan which serves a 30 township area in central Wisconsin.(1)

Manpower shortages still exist, but one potential solution is the use of nurse practitioners and physicians assistants for delivery of primary care. There are still obstacles to this solution, and these midlevel practitioners suffer the same burnout problems as physicians, but more and more are being hired and accepted into the communities.

Rural hospitals are having problems containing costs, but the diversification of larger urban hospitals might have a positive effect for them in the future. Also, since many of them have not had the finances to purchase expensive technology, they will be less affected by the growing fiscal crisis.

State and local health departments have also substantially increased their roles in the direct provision of medical services. In Tennessee, for example, the Department of Public Health established a network of rural primary care centers staffed primarily by nurse practitioners.(1) Many states have included programs in the training of nurse practitioners as well as family practice physicians, with the hope that they will eventually serve in rural areas.

Private foundations such as the Robert Wood Johnson Foundation have also helped. Rural Practice Projects developed by them have developed multidisciplinary practices in rural communities, and many of these should be self-sufficient eventually.

If you are interested in working in rural areas, or are preparing health educators for employment in rural communities, the following suggestions might be helpful.

First ... in few other disciplines are the principles of community organization more important. A rural health educator must be able to assess the needs of the community, understand the power structure, work with board members, committees, volunteers, community leaders, and legislators. Outreach is important; you need to know how to get services to people.

Second ... the health educator must be able to involve the community in solving community health problems. Harcourt Morgan noted that if citizens do not understand the problems and appreciate the need for a well-directed and integrated effort toward their solution, they won't do their part, not as individuals nor as part of their occupational groups.

Third ... health educators working in rural areas appear to function better if they are generalists. This means they have a broad based education in a number of content areas, but also understand the value of small group process, task analysis, policy and planning, health care marketing, program planning, program evaluation, grant writing, and the ability to use a wide variety of teaching aids, or maybe even no aids at all. For those who want to develop further skills, conferences such as the National Conference on Rural Primary Care provide valuable workshops and sessions designed to increase skill levels, and state level organizations such as the Department of Human Resources can prove a valuable resource also.

Fourth ... professional isolation is a problem for some rural health educators. The ongoing stimulation of informal professional interrelationships isn't readily available. For this reason it is important to develop strong linkages with whatever surrounding health care providers and facilities there are. Health educators with experience admonish you to attend any local conferences, workshops, or seminars possible, not only for the information they provide but for the support provided from others doing similar activities.

Fifth ... try not to reinvent the wheel. As far as programs are concerned, community based resources such as health centers, state agencies, regional offices and rural health associations can provide information about programs, materials, and resources to make your job a little easier. There has been something recently called the Community Health Connection which is trying to locate the best health promotion and disease prevention programs they can find, compile them into booklet format and make them available to community based health centers. A service of the Bureau of Health Care Delivery and Assistance, USDHHS, it can assist the rural health educator to build on existing health promotion disease prevention initiatives, develop new programs, and work with other local

organizations on common community concerns. If you have an innovative program you would like to share with others, or would like to have some assistance with this, please see me after this session and I will be glad to provide you with more information. This is one of the best things to come down the pike in years!

Sixth ... understand that social mobility means not only being able to move up, but also being able to move down. I saw a bumper sticker recently that said, "I speak farming." It is so very important that you be able to speak "farming" or "mining" or whatever cultural and occupational language occurs. Something else that appears to help is to be from a rural area yourself, or to least have some interest in rural pursuits in the community in which you work. Rural people still suspect outsiders and city slickers in some areas, and at the very least cultivate locally known people who are more readily accepted as change agents within rural areas.

Seventh ... don't fall into the trap of counting visits to the center as evidence of success of your program. Public health is not something that happens in a clinic; it is something that happens in a person's life. Often we cite our successes and failures by what happens in the clinic building; we tell a person who has hypertension how to monitor himself, what foods to stay away from, to lose weight. Over time we tell a lot of people this, and we note in our annual reports that we've given the message to X number of people, therefore, look at how successful we are. It is very important, though not easy to do, to find out if people are actually changing their behavior - that's the real measure of success. If you don't have the time or the expertise to conduct this type of evaluation yourself, contact a nearby university where these skills can be obtained.

Eighth ... get rid of your false notions about healthy country living. Rural life can be as stressful as urban life - witness the mental illness,

alcoholism, drug abuse, and problems with coping that abound in rural areas. The sources of stress may be different, that's all ...

Ninth ... we must get away from the isolationism of our professions. Effective rural health care delivery depends on the interaction of a number of professionals. Defending one's turf or becoming threatened by professional encroachment obliterates the multidisciplinary approach that is essential to effective health care services. Also, do not be afraid to involve other agencies such as the REA, the County Extension Agency, the Farm Home Administration. There needs to be greatly increased coordination among the various groups who provide services to rural areas to avoid duplication.

Tenth ... have patience. New rural primary care programs grow slowly. Patience is required to survive the three to five year maturation process that leads finally to program stability. If you get discouraged, remember General Creighton Abrams' bit of advice: when eating an elephant, take one bite at a time.

... finally, be as adaptable as you possibly can. Working in rural areas is a challenge without equal. And remember this, if you get discouraged during grant review time: Blessed is he who expects no gratitude, for he shall not be disappointed.

One can hope that rural appropriations will continue, that the greater emphasis on self-care skills will add to the health of rural Americans. For those of us who live in rural areas and who love working with rural people, it is important to remember that there is the basic realization that rural areas will continue to have difficulty in obtaining health care, but that many of the educational and programmatic innovations have been translated into real gains. Health education in rural areas reminds me of Hartley's Law: You can lead a horse to water, but if you can get him to float on his back, you've really got something!

References

1. Rosenblatt, R.A. and Moscovice, I.S. Rural Health Care. New York: John Wiley & Sons, 1982
2. Belt, D. "Wild water, proud people." National Geographic, 163(4):458, April 1983
3. Waller, J.A. "Categorizing Hospital Emergency Departments in Rural Areas." Clinical Medicine, 82:41-47, 1975
4. Naisbitt, J. Megatrends. New York: Warner Books, 1982